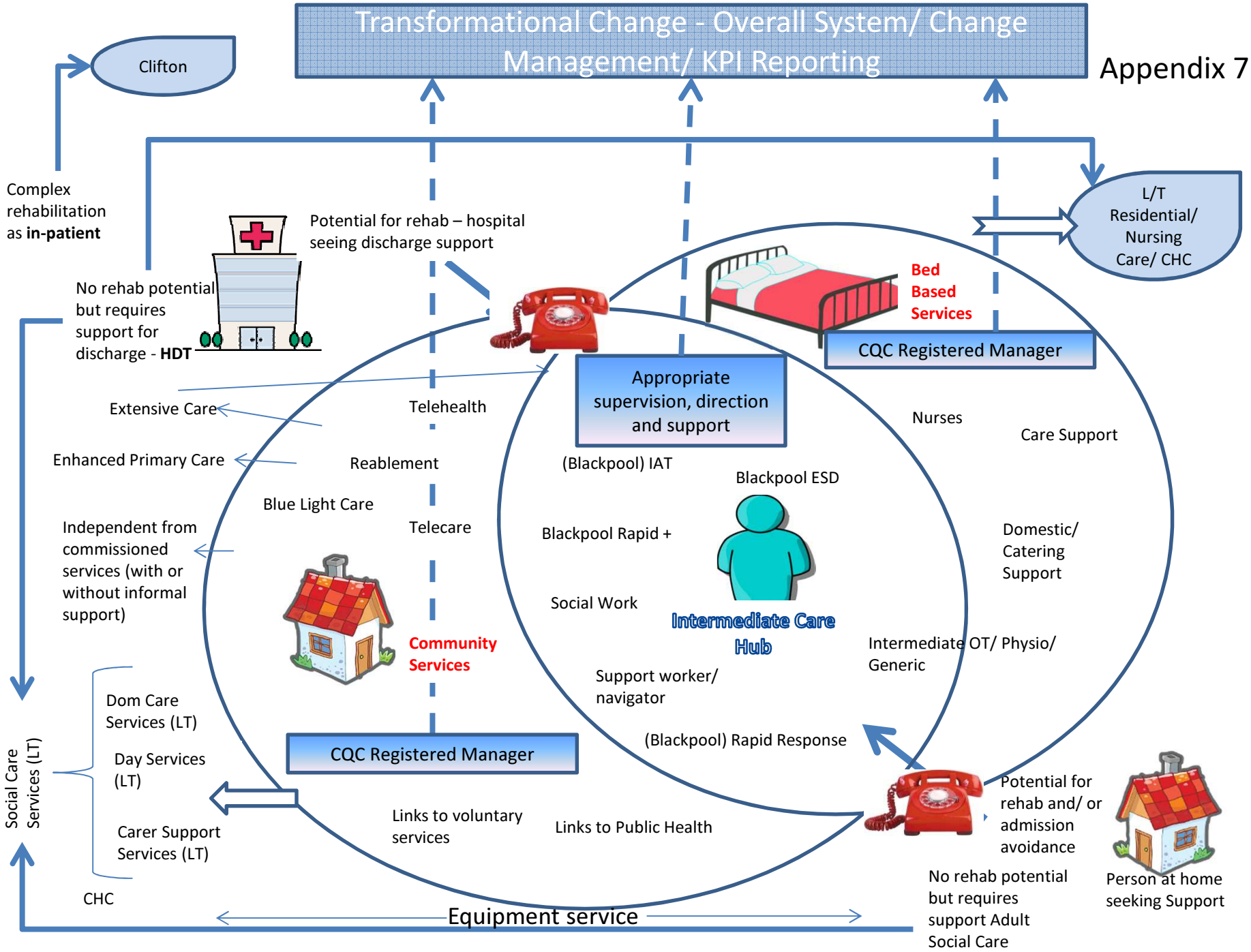
Appendix 7b


Transformational Change - Overall System/ Change Management/ KPI Reporting
Clifton
Complex rehabilitation as **in-patient**
Potential for rehab – hospital seeing discharge support
No rehab potential but requires support for discharge - **HDT**
L/T Residential/ Nursing Care/ CHC
Bed Based Services
CQC Registered Manager
Appropriate supervision, direction and support
Extensive Care
Telehealth
Enhanced Primary Care
Reablement
Blue Light Care
Telecare
Independent from commissioned services (with or without informal support)
Community Services
Nurses
Care Support
(Blackpool) IAT
Blackpool ESD
Blackpool Rapid +
Domestic/ Catering Support
Social Work
Intermediate Care Hub
Intermediate OT/ Physio/ Generic
Support worker/ navigator
(Blackpool) Rapid Response
Dom Care Services (LT)
Day Services (LT)
Carer Support Services (LT)
Social Care Services (LT)
CHC
CQC Registered Manager
Links to voluntary services
Links to Public Health
Potential for rehab and/ or admission avoidance
No rehab potential but requires support Adult Social Care
Person at home seeking Support
Equipment service

Explanatory Notes

1. Patients can be identified by anyone who is supporting the person at home or in hospital. The following key principle will apply to support the identification of patients for the pathway –
   - Diagnosis will not be a barrier to referral. What is important is that the person can engage in a programme of intermediate care.
2. Contact with the hub will be made by telephone. Lines will be available 24/7. The intermediate care hub will be staffed by a multi disciplinary team who are able to make decisions and respond quickly to requests for visits/ discussions with patients. These staff will hold the caseload of people supported though the intermediate care pathway.
3. The intermediate care hub team will have key resources at their disposal to deliver a tailored service – this will include 10 nursing beds, 23 residential beds for intensive assessment and short term support, a team of skilled care workers and telecare/ telehealth. Social Workers and Therapists will work with people across these bases to support the short and long term planning process.
4. The pathway can commence while the patient remains at hospital if aspects of preparatory work are required to facilitate discharge which if not acted on promptly will delay discharge or lengthen intermediate care period.
5. Care and support in the home will be designed to support the person to do as much for themselves as possible, and to follow the goal oriented plan. It will include where required support to access the community, exercise programmes, medication management, dietary support, district Nursing interventions etc.
6. Therapy support will be delivered in the persons own home and some activities may be carried out with by carers as directed by health care professionals and in line with a plan. Some therapy activities may be carried our in group settings in neighbourhood locations to support the reduction of social isolation as well as maximising value.
7. Discharge planning should start as early as possible in the process and the plan will outline how the person can support their own resilience as well as the support they will receive (if any) from others in a formal or non formal way. Where the person has a reliance on another person to meet some aspects of their care needs, good contingency plans will be encouraged.
8. The person “owns” their plan and it will stay with them when the service ends so that they can monitor their own progress toward goals.
9. The patient can access the team directly for advice and support after they have been discharged. This may require information and advice, or access back in to the intermediate care process to prevent or halt a deterioration.